Commonwealth of Massachusetts
Executive Office Health and Human Services

RY2015 EOHHS Manual Release Notes
(Version 8.1a)

Supplement to:
RY 2015 EOHHS Technical Specifications Manual for Acute Hospital Quality Measures

Published: July 31, 2015

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Section I. Introduction to EOHHS Release Notes

A. Purpose of Release Notes

The EOHHS Release Notes (version 8.1a) provide updates applicable to the existing RY15 EOHHS Technical Specifications Manuals published for hospitals participating in MassHealth Hospital Pay-for-Performance (P4P) quality measures reporting. Information in this document addresses the impact of the important updates listed below.

1) Important Updates

- ***ICD-10 Conversion*** – Version 8.1a provides substantive updates on changes to all measure data collection and reporting due to ICD-10 conversion requirements that begin with October 1, 2015 discharges. This change will impact MassQEX portal data file processing and measure calculations.

- ***National Specifications*** – Version 8.1a also provides updates on specific clinical data elements to conform to new clinical standardized descriptions affecting maternity measure calculations.

- ***Quarter Period Impact*** - The effective implementation date of changes outlined throughout this document begin with Q4-2015 (Oct 1, 2015 – Dec 31, 2015) discharge data file reporting.

2) **Manual Versions**: For RY15, three separate versions of the Manuals are published as follows:

- EOHHS Manual and Appendix tools (v8.0) - Full version during interim MassQEX transition.
- EOHHS Manual (v 8.1) - Updates that were made after the MassQEX transition.
- EOHHS Release Notes (v8.1a) – Updates to address impact of important updates noted above.
- EOHHS Appendix tools (v8.1a) – Updates to select data tools impacted by important updates.

Hospitals are responsible for downloading and using the appropriate versions of EOHHS Technical Specifications Manual that apply to each quarterly discharge data period being collected and submitted. Failure to adhere to appropriate versions of the EOHHS Manual will result in portal rejecting data files.

B. Guidelines for Using Release Notes

The EOHHS Release Notes are organized to follow the RY15 Technical Specs Manual sections and Appendix format as listed in the table of contents. Updated information is provided under each manual section using the following headings:

- **Key Impact** – identifies the measures and the EOHHS Manual section that is impacted by the change listed (i.e.: measure specifications, data tools, dictionary, etc.). A key impact is defined as information that will affect data collection and reporting requirements.

- **Rationale** – a brief statement on the reason why the change is being made.

- **Description of Change** – identifies the specific content within the manual section where the change was made. (i.e.: numerator/denominator statement, flowcharts, data format, allowable values, etc.).

The Release Notes (v8.1a) should be used as a reference and are not intended to replace the full set of RY15 EOHHS Manual versions noted above that impact CY2015 data reporting requirements.

Please contact the MassQEX Help Desk at 844-546-1343 or massqexhelp@telligen.com if you have any questions about information in this document or EOHHS Manual version instructions apply to reporting.

Section II. Updates to EOHHS Manual (v 8.1) Sections

This portion of the Release Notes is organized to follow the order of the sections in the RY15 EOHHS Manual (v8.1) Table of Contents. Within each section the text lists the key impact or change, rationale for the change and description of change.

Section 1: Introduction

Key Impact: **Section 1.C** Acute RFA Data Submission Cycles (Table 1.1)
Rationale: Update status of Q3-2015 and Q4-2015 due date reporting cycle schedule.

Description of Change
- The Q3-2015 and Q4-2015 data reverts back to separate quarterly reporting cycles shown in Table below.

Acute RFA Data Submission Cycles (RY15-16)

Acute RFA Contract Year	CY Quarter Data Reporting Cycle	Discharge Data Periods	Submission Deadline	EOHHS Manual Instructions
Rate Year 2016	Quarter 1-2015 Quarter 2-2015	Jan 1, 2015 – Mar 31, 2015 April 1, 2015 - June 30, 2015	Nov 13, 2015*	Version 8.0 and Version 8.1
Rate Year 2016	**Quarter 3-2015***	July 1, 2015 – Sept 30, 2015	Feb 12, 2016	Version 8.0 and Version 8.1
	Quarter 4-2015*	Oct 1, 2015 – Dec 31, 2015	May 13, 2016	Release Notes v8.1a Appendix v 8.0 & 8.1a

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Key Impact: All References in EOHHS Manual (v8.1) pointing to nationally reported measure requirements
Rationale: Correct typographical errors referencing Section 3.F to Section 3.G

Description of Change
- Reposted EOHHS Manual (v8.1) with corrections in Table of Contents, pages 3, 4, 6, 10, 11, 68, 74 and 86.
- Hospitals can print corrected pages to replace content of their EOHHS Manual (v8.1).

Section 2: Data Collection Standards & Guidelines

Key Impact: Section 2.A General Data Element Technical Manual Instructions
Rationale: Update initial patient population references due to conversion of ICD-10 codes and other elements.

Description of Change:
- EOHHS Manual (v8.1) – use this version for Q1-2015 to Q3-2015 data file reporting.
- EOHHS Release Notes (v8.1a) – use this version for Q4-2015 data file reporting.
- NHQIM Manual (v 5.0a) - use this version of Appendix A: ICD-10 code tables for ED and TOB Q4-2015 data.
- TJC Manual (v2015B) – use this version of Appendix A: ICD-10 code tables for MAT measures Q4-2015 data.

Key Impact: Section 2.D Data Reporting Tool Versions
Rationale: Update initial patient population due to conversion of ICD-10 codes and maternity data elements.

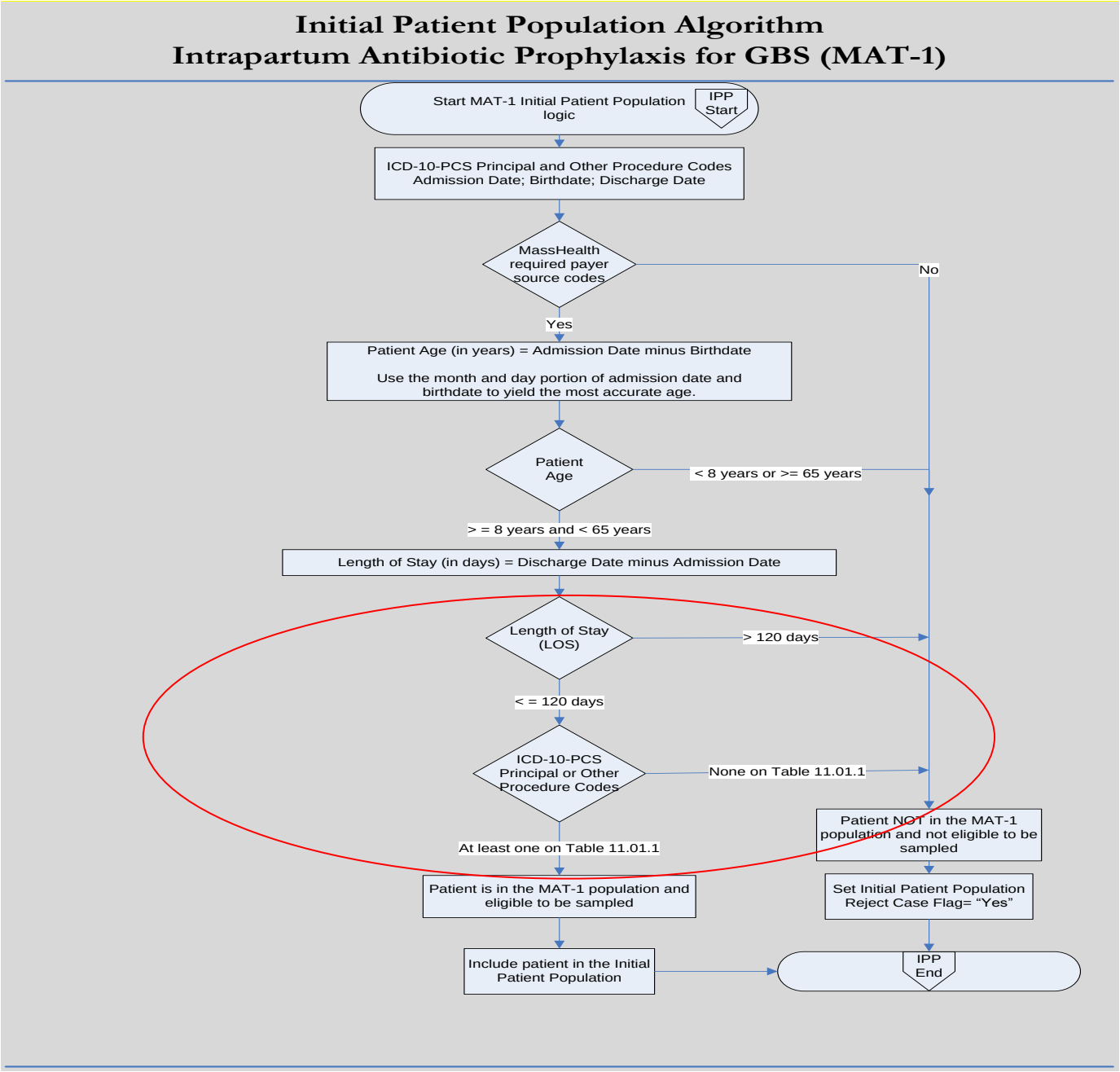
Description of Change:
- Appendix tool versions (v8.0) listed in Table 2.4 have been updated. New versions for Appendix A-3, A-4, A-6 and A-10 tools apply to Q4-2015 reporting. Refer to page 27 of this EOHHS Release Notes document for additional information.

Section 3: MassHealth Quality Measure Specifications

Key Impact: **Section 3.A** MAT-1 Measure
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes.

Description of Change:

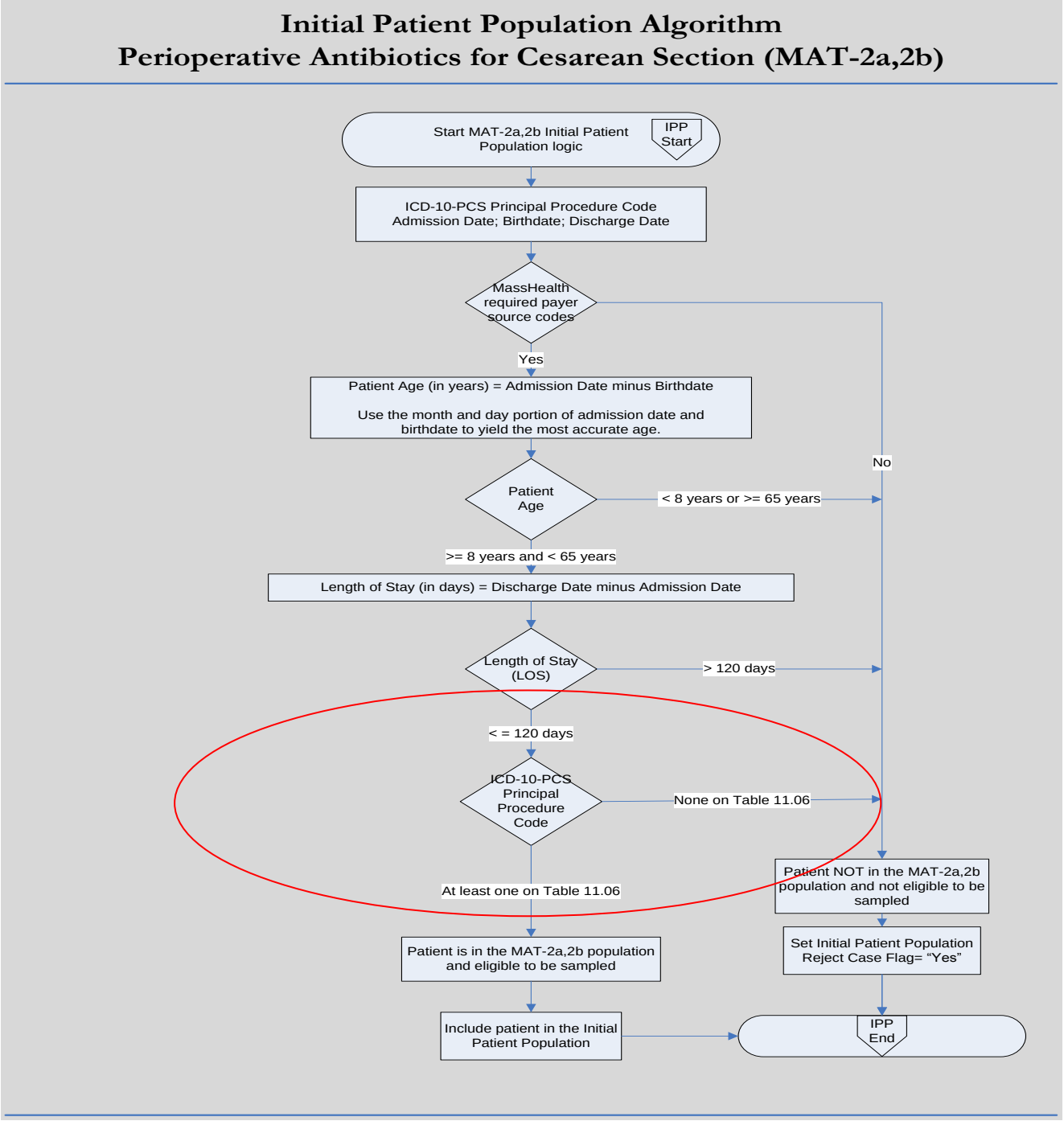
- **Denominator statement**: Change included population to ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A: ICD-10 code Table 11.0.1 in TJC Manual version 2015B.
- **Measure Flowchart –** Change start flowchart references to ICD-10-PCS Principal or Other Procedure Codes and after the length of stay (in days) with another reference to ICD-10 –PCS where none is on new Table 11.01.1. The specific measure flowchart portion is inserted below to illustrate where the algorithm is impacted by the key change described above. Use this updated illustration in conjunction with EOHHS Manual (v8.1) which contains the full version of the measure description and flowchart that applies to this measure.



Key Impact: Section 3.B and 3.C for MAT-2a and MAT-2b Measure
Rationale: Update initial patient population references due to conversion of ICD-10 codes.

Description of Change:

- **Denominator statement**: Change included population to ICD-10-PCS Principal Procedure Code for cesarean section as defined in Appendix A: ICD-10 code Table 11.06 in TJC Manual version 2015B.
- **Measure Flowchart –** Change start flowchart references to ICD-10-PCS Principal Procedure Code and none in Table 11.06. The specific measure flowchart portion is inserted below to illustrate where the algorithm is impacted by the key change described above. Use this updated illustration in conjunction with EOHHS Manual (v8.1) which contains the full version of the measure description and flowchart that applies to this measure.



Key Impact: Section 3.D MAT-3 Measure
Rationale: Update initial patient population references due to conversion of ICD-10 codes.

Description of Change:

- **Numerator Statement**: Change included population to ICD-10-PCS Principal or Other Procedure Code for one or more of the following:
    - Medical induction of labor as defined in Appendix A: ICD-10 code Table 11.05 while not in labor prior to the procedure;
    - Cesarean birth as defined in Appendix A ICD-10 code Table 11.06
- **Numerator Data Elements:**
    - Change to ICD-10-PCS Other Procedure Code
    - Change to ICD-10-PCS Principal Procedure Code

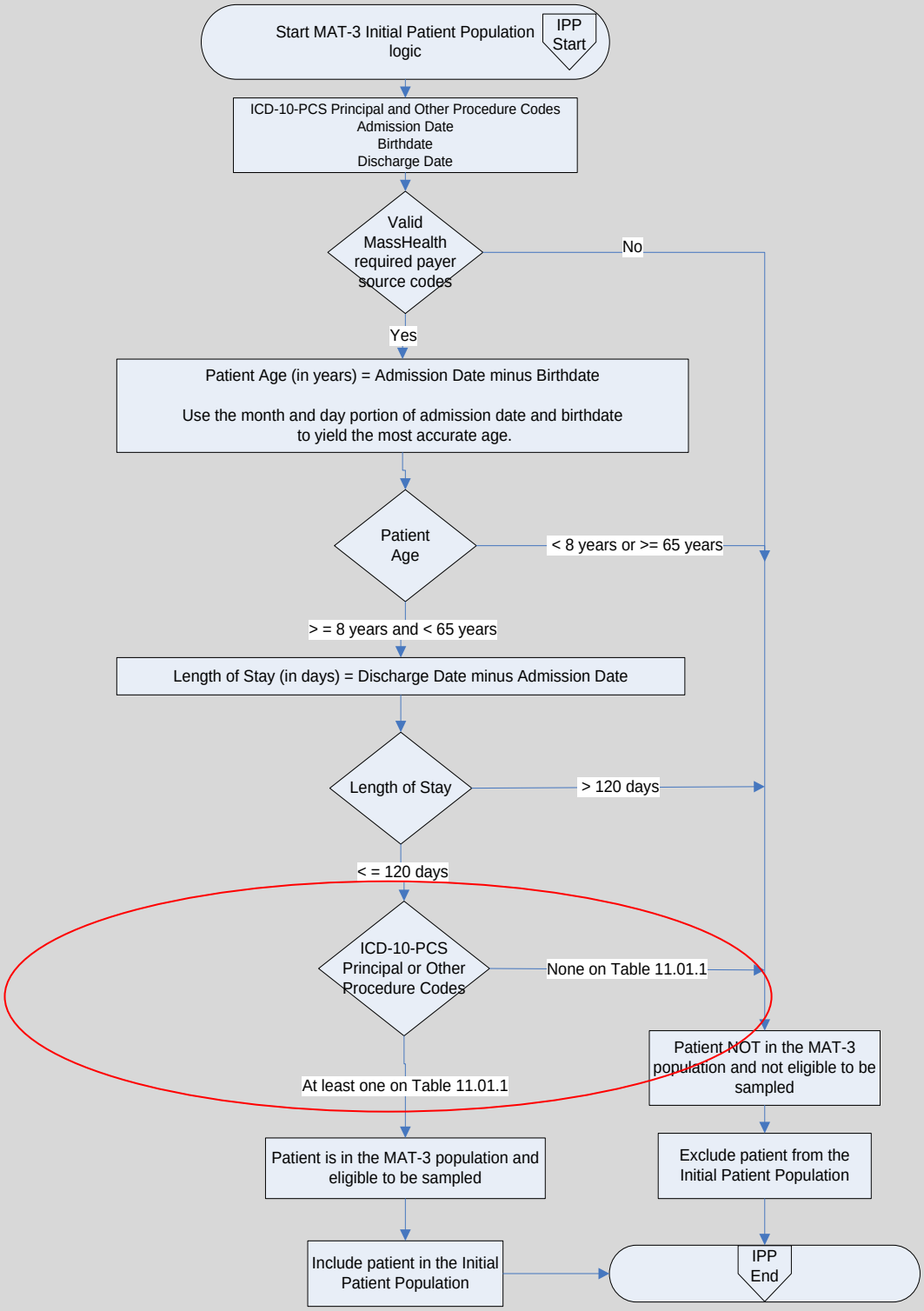
- **Denominator statement**: Change included population to:
    - First bullet, to ICD-10-PCS Principal Procedure Code or Other Procedure Code for delivery as defined in Appendix A: ICD-10 code Table 11.01 in TJC Manual version 2015B.
    - Second bullet, to ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Code for planned cesarean birth as defined in Appendix A: ICD-10 code Table 11.06.1 in TJC Manual version 2015B.
    - Third bullet, to ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Code for conditions possibly justifying elective delivery as defined in Appendix A: ICD-10 code Table 11.07 in TJC Manual version 2015B
- **Denominator Data Elements:**
    - Change to ICD-10-CM Other Diagnosis Code
    - Change to ICD-10-CM Principal Diagnosis Code

- **Data Accuracy:** change ICD-9 reference to ICD-10 code

- **Measure Analysis Suggestion**: change ICD-9 reference to ICD-10 code.

- **Measure Flowchart –** Change references to:
    - Start measure flowchart change label to ICD-10-PCS Principal or Other Procedure Codes and none on Table 11.01.1
    - Begin 2 measure flowchart change label to ICD-10-CM Principal or Other Diagnosis Codes and at least one on Table 11.07
    - Begin 3 measure flowchart change label to ICD-10-CM Principal or Other Diagnosis Codes and at least one on Table 11.06.1 followed by to ICD-10-PCS Principal or Other Procedure Codes and at least one on Table 11.05 followed by ICD-10-PCS Principal or Other Procedure Codes and none on Table 11.06 The full version of this measure flowchart is inserted below to illustrate where portions of the algorithm are impacted by the key changes described above. Use this updated illustration in conjunction with EOHHS Manual (v8.1) which contains the full version of the measure description.

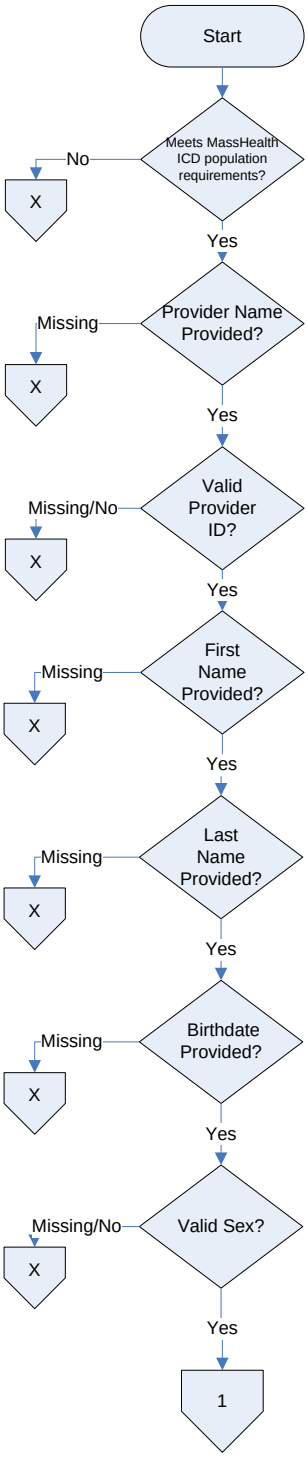
Initial Patient Population Algorithm
Elective Delivery (MAT-3)



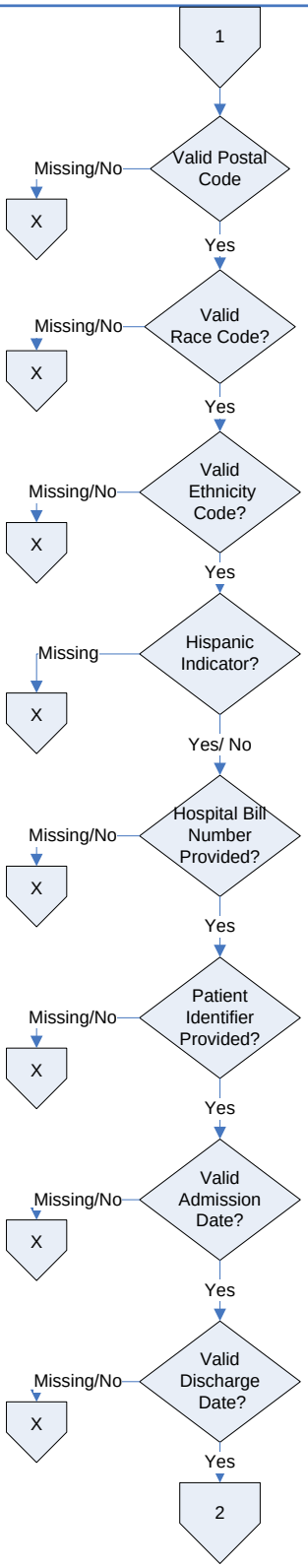
Elective Delivery (MAT-3)

***Numerator:** Patients with elective deliveries completed

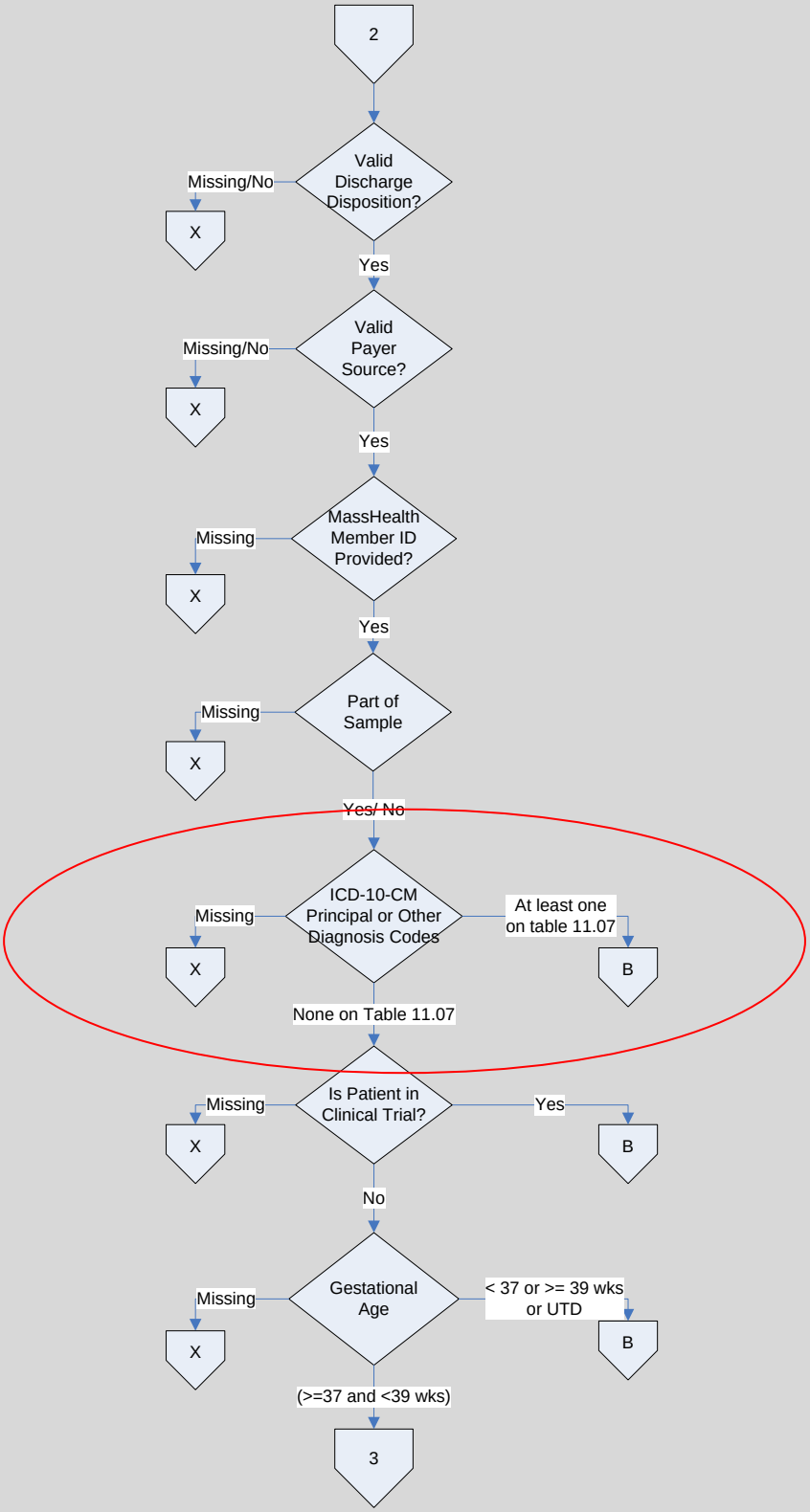
***Denominator:** Patients delivering newborns with >= 37 and <39 weeks gestation completed



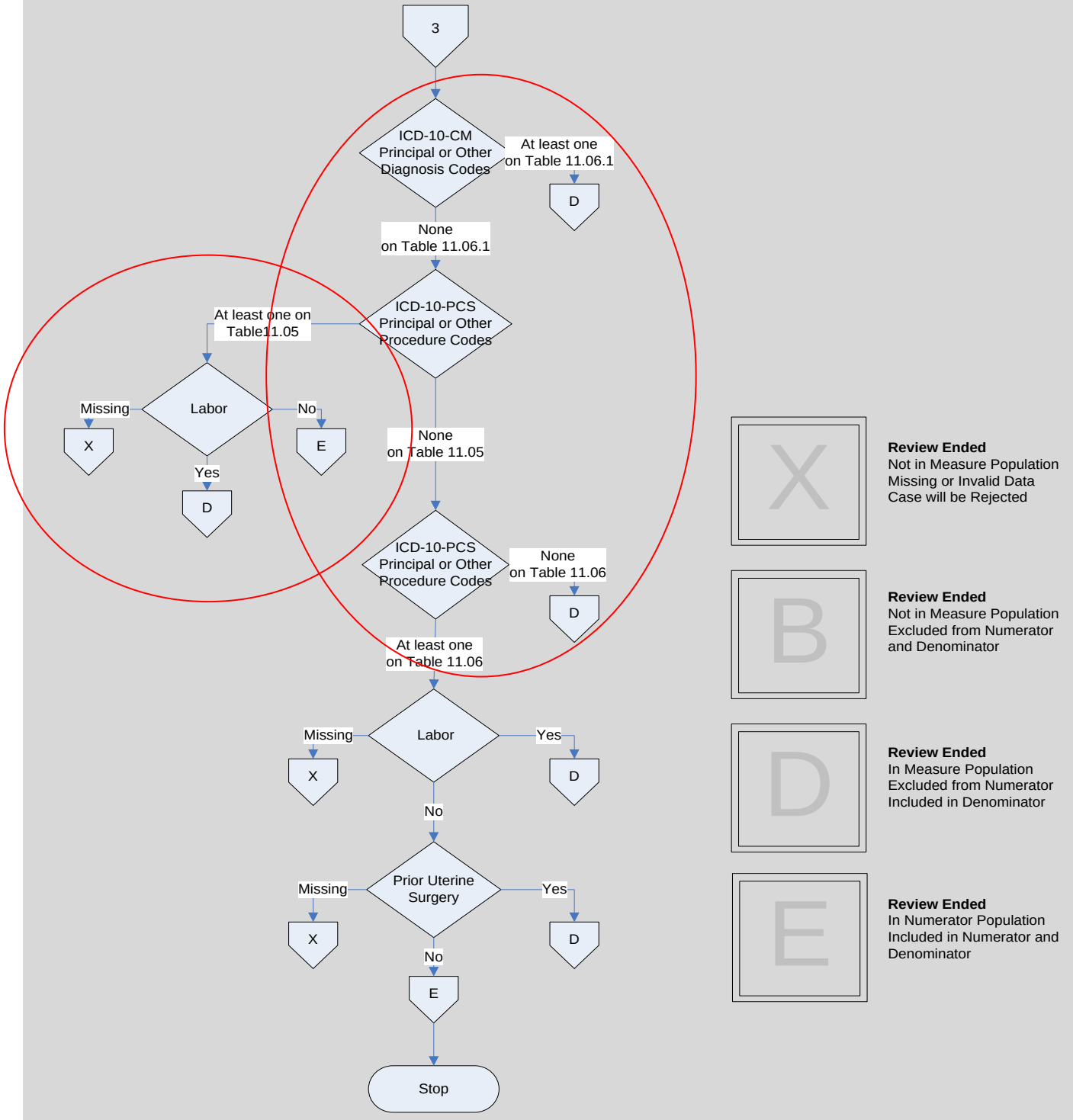
Elective Delivery (MAT-3)



Elective Delivery (MAT-3)



Elective Delivery (MAT-3)



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Key Impact: Section 3.E MAT-4 Measure
Rationale: Change measure name to cesarean birth and parity data element name to conform with new ACOG standardized description and TJC specifications. Update initial patient population ICD-9 references due to conversion of ICD-10 codes.

Description of Change:

- **Rationale Statement**: All language stating 'cesarean section' has been changed to 'cesarean birth (CB)'.

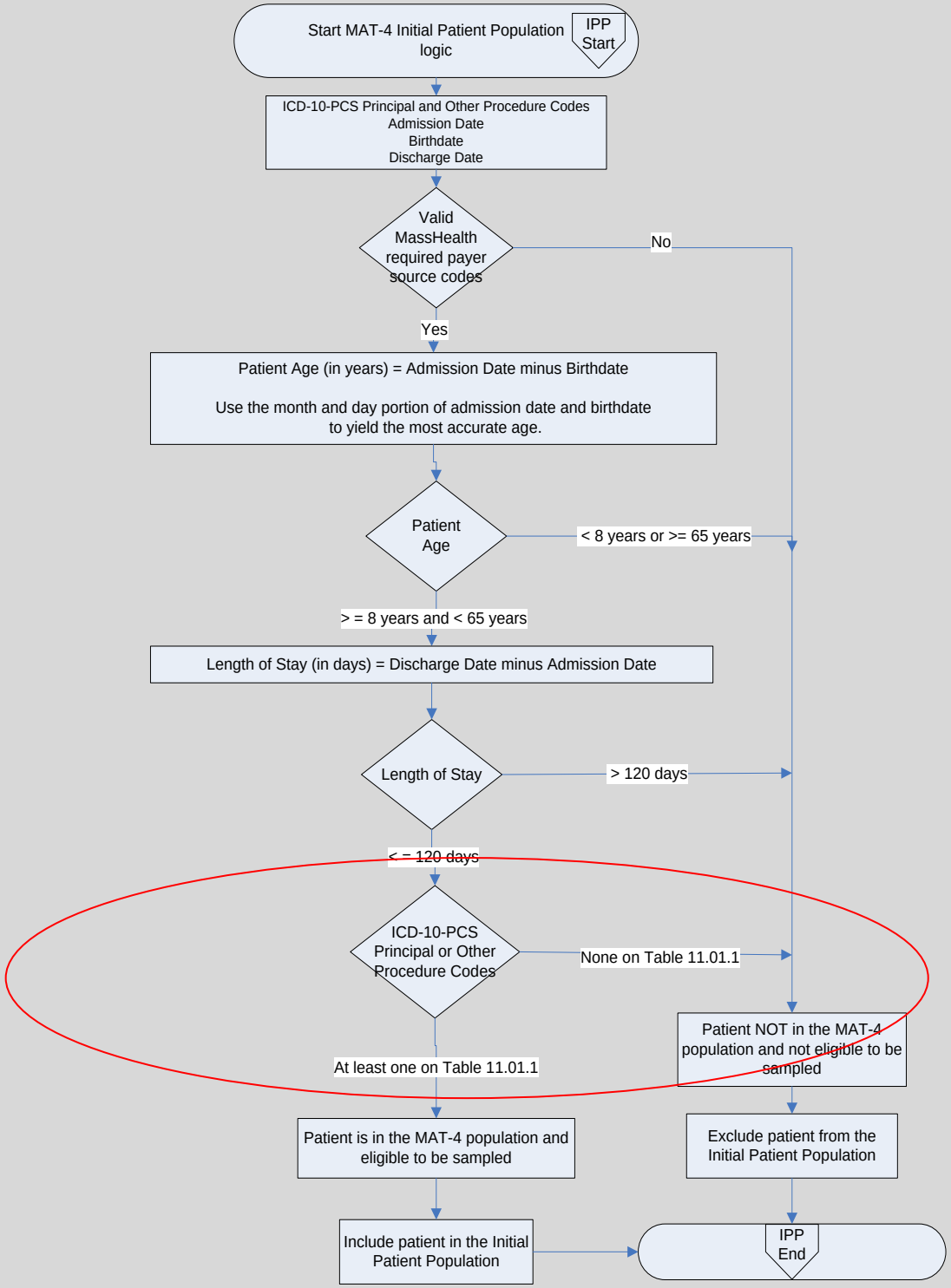
- **Numerator Statement:** change to patient with cesarean birth
  - Change included population to ICD-10-PCS Principal Procedure or Other Procedure Code for cesarean birth as defined in Appendix A: ICD-10 code Table 11.06 in TJC Manual version 2015B.
  - Change to nulliparous patients with ICD-10.
- **Numerator Data Elements:**
  - Change to ICD-10-PCS Other Procedure Code
  - Change to ICD-10-PCS Principal Procedure Code
- **Denominator statement**: Change included population to:
  - ICD-10-PCS Principal Procedure Code or Other Procedure Code for delivery as defined in Appendix A: ICD-10 code Table 11.01 in TJC Manual version 2015B.
  - Nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Code for outcome of delivery as defined in Appendix A: ICD-10 code Table 11.08 in TJC Manual version 2015B.
- **Denominator statement**: Change excluded population to:
  - ICD-10-CM Principal Diagnosis Code or Other Diagnosis Code for multiple gestations and other presentations as defined in Appendix A: ICD-10 code Table 11.09 in TJC Manual version 2015B.
- **Denominator Data Elements:**
  - Change to ICD-10-CM Other Diagnosis Code
  - Change to ICD-10-CM Principal Diagnosis Code
  - Change Parity data element name to 'Number of previous live births'.

- **Data Accuracy:** change ICD-9 reference to ICD-10 code

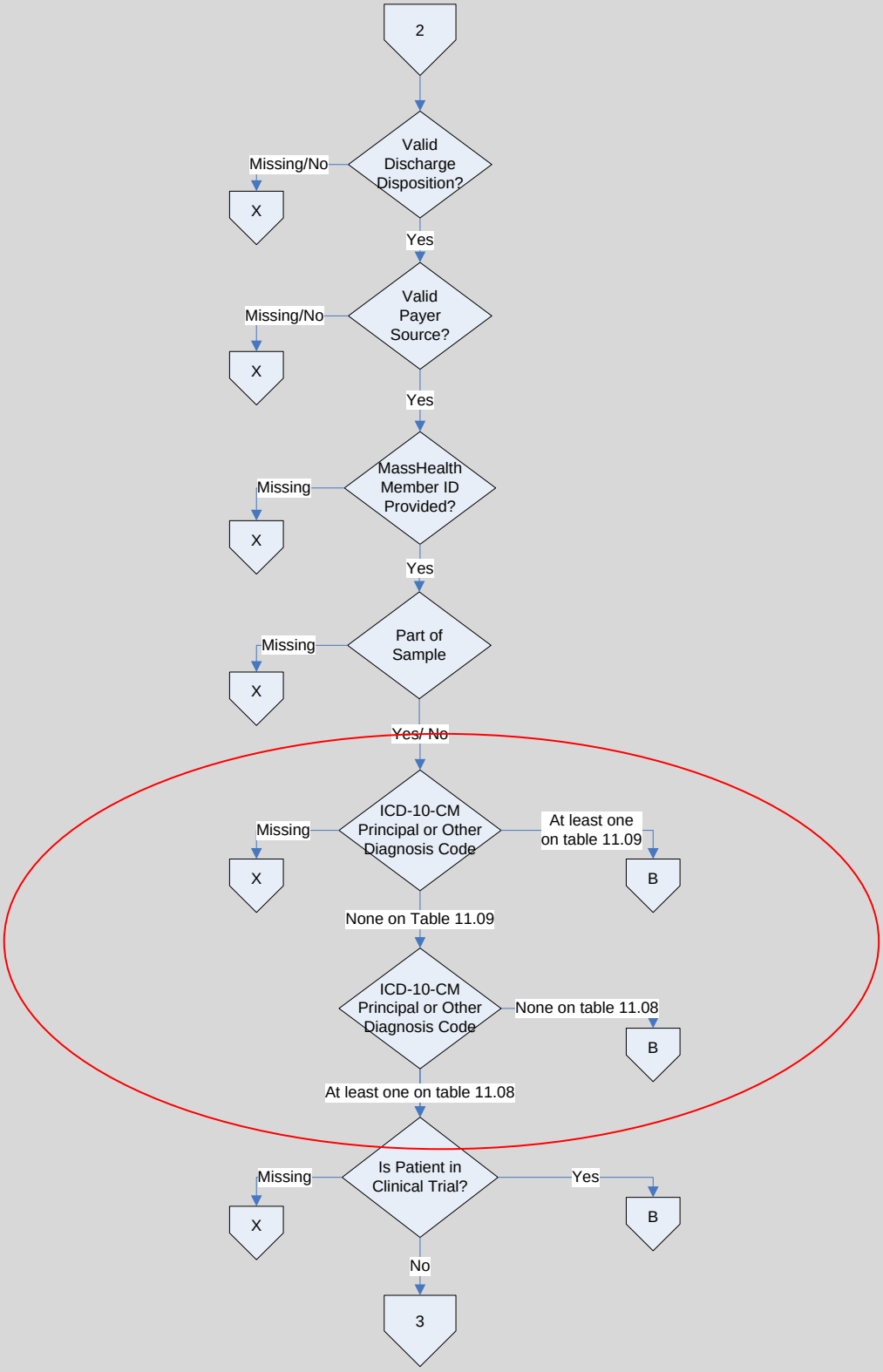
- **Measure Analysis Suggestion**: change ICD-9 reference to ICD-10 code.

- **Measure Flowchart –** Change references to:
  - Start IPP flowchart change label to ICD-10-PCS Principal or Other Procedure Codes and none on Table 11.01.1
  - Begin 2 measure flowchart change label to ICD-10-CM Principal or Other Diagnosis Codes and at least one on Table 11.09 and none in Table 11.08
  - Begin 3 measure flowchart change label to "Number of Live Births" followed by ICD-10-PCS Principal or Other Procedure Codes all missing or none in Table 11.06.
    The full version of this measure flowchart is inserted below to illustrate where portions of the algorithm are impacted by the key changes described above. Use this updated illustration in conjunction with EOHHS Manual (v8.1) which contains the full version of the measure description.

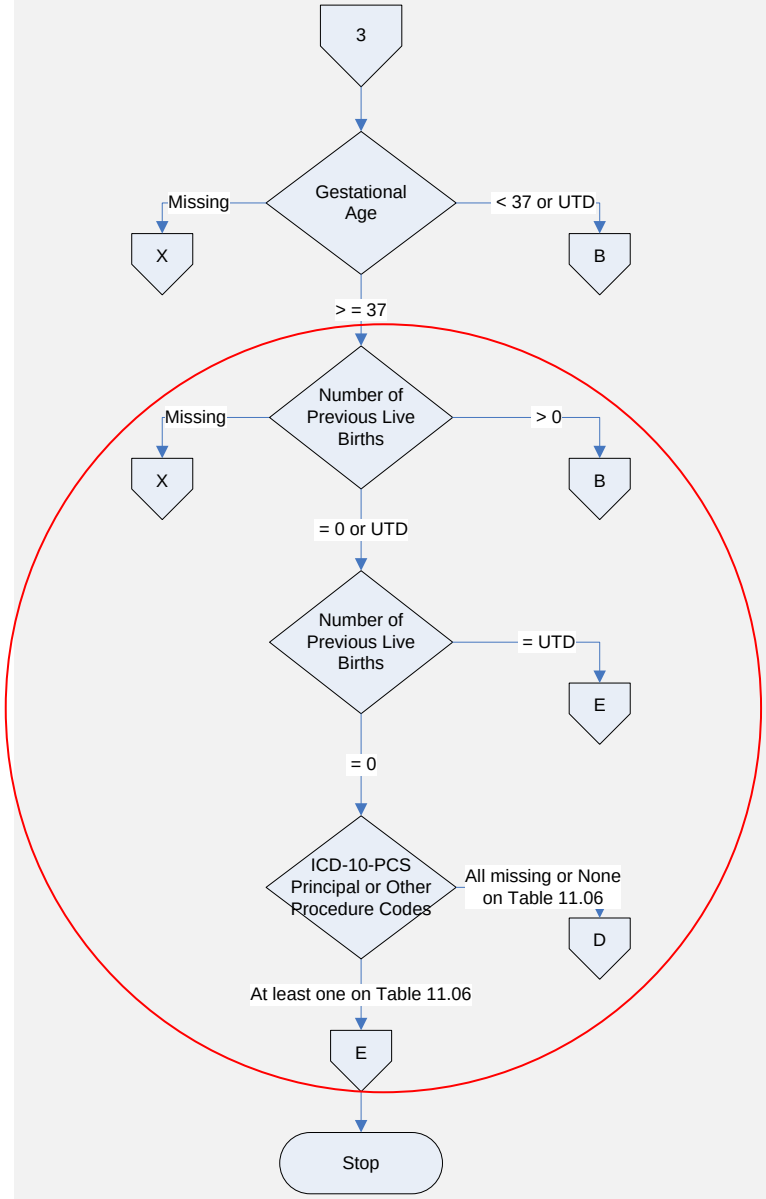
Initial Patient Population Algorithm
Cesarean Birth (MAT-4)



Cesarean Birth (MAT-4)



Cesarean Birth (MAT-4)



Review Ended
Not in Measure Population
Missing or Invalid Data
Case will be Rejected

Review Ended
Not in Measure Population
Excluded from Numerator and Denominator

Review Ended
In Measure Population
Excluded from Numerator
Included in Denominator

Review Ended
In Numerator Population
Included in Numerator and Denominator

Key Impact: Section 3.G: Nationally Reported Measure Requirements
Rationale: Update initial patient population reference ICD code tables due to conversion of ICD-10 codes.

Description of Change:

- Change emergency department measures (ED-1, ED-2) specification references to Appendix A: ICD-10 code tables in NHQIM Manual (version 5.0a) and Release Notes (5.0a)
- Change tobacco measures (TOB-1, 2, 3) specification references to Appendix A: ICD-10 code tables in NHQIM Manual (version 5.0a) and Release Notes (5.0a)

Section 4: Medicaid Sampling Specifications

Key Impact: Section 4.A and 4.E: Definition of Initial Patient Population
Rationale: Update initial patient population references due to conversion of ICD-10 codes.

Description of Change:

- All language in section text referencing ICD-9 codes is now identified as ICD-10.

Section 5: Data Transmittal Guidelines

Key Impact: Section 5.A.2: XML Schema Version (v 8.0)
Rationale: Update initial patient population references due to conversion of ICD-10 codes.

Description of Changes:

- XML schema (v8.1a) – use this version of MassHealth Specific Measures File to report MAT and CCM for Q4-2015 discharge data only.
- XML schema (8.0) – use this version MassHealth Identifier Crosswalk File to report ED and TOB for Q4-2015 discharge data only.

Section 6: Data Validation Methods

- No key changes to this Appendix document were made.

Section 7: Health Disparities Specifications

- No key changes to this Appendix document were made.

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Section 8: Other Hospital Program Information

- No key changes to this Appendix document were made.

Section III. Updates to EOHHS Manual Appendix (v8.0) Tools

This portion of the Release Notes is organized to follow the order of the Appendix sections listed in the RY15 EOHHS Manual Table of Contents. Under each Appendix section the text lists the key impact or change, rationale for the change and description of change.

Appendix A-1: Data Abstraction Tool: (MAT-1)

- No key changes to this Appendix document were made.

Appendix A-2: Data Abstraction Tool: (MAT-2a, 2b)

- No key changes to this Appendix document were made

Appendix A-3: Data Abstraction Tool: (MAT-3)

Key Impact: MAT-3 Data abstraction tool questions Q.19, Q.21 to Q.26
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes plus the gestational age and labor data element questions to conform to ACOG standardized descriptions.

Description of Changes

- Q.19 Change to ICD-10-CM Principal or Other Diagnosis Codes (Table 11.07)
- Q.21 Change question" to how many weeks of gestation were completed at time of delivery'
- Q.22 Change to ICD-10-CM Principal or Other Diagnosis Codes (Table 11.06.1)
- Q.23 Change to ICD-10-PCS Principal or Other Procedure Codes (new Table 11.05) and response instructions
- Q.24 Add question to 'Is there documentation by clinician that patient was in labor prior to induction and/or cesarean birth. Change to response instructions
- Q.25 Change to ICD-10-PCS Principal or Other Procedure Codes (Table 11.06)
- Q.26 Change question ending starting with was in labor 'prior to induction and/or cesarean birth.

Appendix A-4: Data Abstraction Tool: Cesarean Birth (MAT-4)

Key Impact: MAT-4 Data abstraction tool questions Q.19, Q.20, and Q22 to Q.24
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes. Update gestational age and live birth data element questions to conform to ACOG standardized descriptions.

Description of Changes

- Q.19 Change to ICD-10-CM Principal or Other Diagnosis Codes (Table 11.09)
- Q.20 Change to ICD-10-CM Principal or Other Diagnosis Codes (new Table 11.08)
- Q.22 Change question to 'how many weeks of gestation were completed at the time of delivery'
- Q23. Change question to 'how many deliveries resulting in a live birth'…. (NUMPLB)
- Q.24 Change to ICD-10-PCS Principal or Other Procedure Codes (new Table 11.06)

Appendix A-5: Data Abstraction Tool: (CCM-1, 2, 3)

- No key changes to this Appendix document were made.

Appendix A-6: XML Schema: MassHealth Specific Measures File

Key Impact: Table A Column field data element names and entry codes and values
Rationale: Update ICD-9 references due to conversion of ICD-10 codes and TJC measure specifications.

Description of Changes

- The description of changes are organized using a table header that list the changed data element name, question/field name, data type, length and answer codes and values affecting the element name. The reader can identify the exact location of changes by reading from left to right across the five columns in table shown below.

Change to Element Name	Change to Question/Field Name	Change to Data Type	Change to Length	Change to Answer Codes and Answer Values
Gestational Age	Question wording , GESTAGE	No change	No change	No change
ICD-10-CM Other Diagnosis code	OTHRDX#	Character	3 - 7	ICD10-CM diagnosis code without decimal point or dot, upper or lower case
ICD-10-PCS Other Procedure Codes	OTHRPX#	Character	3 - 7	ICD10-PCS procedure code without decimal point or dot, upper or lower case
ICD-10-PCS Other Procedure Date	OTHRPX#DT	Character	3 - 7	ICD10-PCS procedure code without decimal point or dot, upper or lower case
ICD-10-CM Principal Diagnosis Code	PRINDX#	Character	3 - 7	ICD10-CM diagnosis code without decimal point or dot, upper or lower case
ICD-10-PCS Principal Procedure Code	PRINPX#	Character	3 - 7	ICD10-PCS procedure code without decimal point or dot, upper or lower case
ICD-10-PCS Principal Procedure Date	PRINPX#DATE	Character	3 - 7	ICD10-PCS procedure code without decimal point or dot, upper or lower case
Labor	Question wording, ACTLABOR	No change	No change	No change
Number of Previous Live Births	Field name to NUMPLB	Numeric	2 or UTD	0 - 50. UTD
Parity	Retired	Retired	Retired	Retired

Appendix A-7: XML Schema: MassHealth Identifier Crosswalk File

- No key changes to this Appendix document were made.

Appendix A-8: XML Schema: MassHealth Data Deletion Request File

- No key changes to this Appendix document were made.

Appendix A-9: Data Dictionary: MassHealth Specific Measures

This portion of the Release Notes identifies the select data dictionary data elements impacted by important updates described in the introduction of this document. These specific changes are shown in underline italic font.

Key Impact: ICD-9-CM Other Diagnosis Code
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes.

Description of Changes:

Data Element Name:	*ICD-10-CM Other Diagnosis Codes*
Collected For:	All MassHealth Records
Definition:	The other or secondary *ICD-10-CM* codes associated with the diagnosis for this hospitalization.
Suggested Data Collection Question:	What were the *ICD-10-CM* other diagnosis codes selected for this medical record?
Format:	Length: *3-7 (without decimal point or dot)* Type: *Character(upper or lower case)* Occurs: 24
Allowable Values:	Any valid diagnosis code as per the CMS *ICD-10-CM master code table (2015 Code Descriptions in Tabular Order):* *http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html*

Key Impact: ICD-9-CM Other Procedure Code
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes.

Description of Changes:

Data Element Name:	*ICD-10-PCS Other Procedure Codes*
Collected For:	All MassHealth Records
Definition:	The other or secondary *ICD-10-PCS* codes identifying all significant procedures other than the principal procedure.
Suggested Data Collection Question:	What were the *ICD-10-PCS* code(s) selected as other procedure(s) for this record?
Format:	Length: *3-7 (without decimal point or dot)* Type: *Character(upper or lower case)* Occurs: 24
Allowable Values:	Any valid procedure code as per the *CMS ICD-10-PCS master code table (2015 PCS Long and Abbreviated Titles):* *http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html.*

Key Impact: ICD-9-CM Other Procedure Dates
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes.

Description of Changes:

Data Element Name:	*ICD-10-PCS Other Procedure Dates*
Collected For:	All MassHealth Records
Suggested Data Collection Question:	What were the date(s) the other procedure(s) were performed?
Notes for Abstraction:	• If the procedure date for the associated procedure is unable to be determined from the medical record, select "UTD". • The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not valid format/range or outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD." Examples:

- Documentation indicates the *ICD-10-PCS Other Procedure Dates* was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the *ICD-10-PCS Other Procedure Dates* is outside of the range listed in the Allowable Values for "Day," It is not a valid date and the abstractor should select "UTD."
- Patient expires on 02-12-20xx and documentation indicates the *ICD-10-PCS* Other Procedure Dates was 03-12-20xx. Other documentation in the medical records supports the date of death as being accurate. Since the *ICD-10-PCS Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters of care and abstractor should select "UTD."

Notes: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ICD-10-PCS Other Procedure Dates* allows the case to be accepted in the warehouse.

Key Impact: ICD-9-CM Principal Diagnosis Codes
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes.

Description of Changes:

Data Element Name:	*ICD-10-CM Principal Diagnosis Code*
Collected For:	All MassHealth Records
Definition:	The *ICD-10-CM* diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.
Suggested Data Collection Question:	What was the *ICD-10-CM* code selected as the principal diagnosis for this record?
Format:	Length: *3-7 (without decimal point or dot)* Type: *Character (upper or lower case)* Occurs: 1
Allowable Values:	Any valid diagnosis code as per the *CMS ICD-10-CM master code table (2015 Code Descriptions in Tabular Order): http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html.*

Key Impact: ICD-9-CM Principal Procedure Code
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes.

Description of Changes:

Data Element Name:	*ICD-10-PCS Principal Procedure Code*
Collected For:	All MassHealth Records
Definition:	The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.
Suggested Data Collection Question:	What was the *ICD-10-PCS* code selected as the principal procedure for this record?
Format:	Length: *3-7 (without decimal point or dot)* Type: *Character (upper or lower case)* Occurs: 1
Allowable Values:	Any valid procedure code as per the *CMS ICD-10-PCS master code table (2015 PCS Long and Abbreviated Titles): http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html.*

Key Impact: ICD-9-CM Principal Procedure Date
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes.

Description of Changes:

Data Element Name:	*ICD-10-PCS Principal Procedure Date*
Collected For:	All MassHealth Records
Definition:	The month, day, and year when the principal procedure was performed.
Suggested Data Collection Question:	What was the date the principal procedure was performed?
Notes for Abstraction:	If the principal procedure date is unable to be determined from medical record documentation, select "UTD." The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not valid date/format or is outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD." Examples: • Documentation indicates the *ICD-10-PCS Principal Procedure Date* was 02-42-20xx. No other documentation n the medical record provides a valid date. Since the *ICD-10-PCS Principal Procedure Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD." • Patient expires on 02-12-20xx and documentation indicates the *ICD-10-PCS Principal Procedure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-10-PCS Principal Procedure Date* is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select "UTD." Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ICD-10-PCS Principal Procedure Date* allows the case to be accepted into the warehouse.

Key Impact: Gestational Age
Rationale: Update data element definition, collection question, and notes for abstraction to conform to ACOG revised calculation of gestational age.

Description of Changes:

Data Element Name:	Gestational Age
Collected For:	MAT-1, MAT-3, MAT-4
Definition:	The *weeks of gestation completed* at the time of delivery. *Gestational age is defined as the best obstetrical estimate (OE) of the newborn's gestation in completed weeks based on the birth attendant's final estimate of gestation, irrespective of whether the gestation results in a live birth or a fetal death. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the newborn exam. Ultrasound taken early in pregnancy is preferred (source: American College of Obstetricians and Gynecologists reVITALize Initiative).*
Suggested Data Collection Question:	*How many weeks of gestation were completed at the time of delivery?*
Format:	Length: 3 or UTD Type: Alphanumeric Occurs: 1
Allowable Values:	In completed weeks No leading zero UTD

1-50

Notes for Abstraction: Use completed weeks of gestation, do not "round up." For example, an infant born at 35 weeks 6 days is at a gestational age of 35 weeks.

The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical; prenatal forms; clinician admission progress note and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

If the patient has not received prenatal care *and no gestational age was documented*, select allowable value UTD.

When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date.

Gestational age should be documented by the clinician as a numeric value between 1-50. *Gestational age (written with both weeks and days, e.g. 39 weeks and 0 days) is calculated using the best obstetrical Estimated Due Date (EDD) based on the following formula: Gestational Age = (280 - (EDD - Reference Date)) / 7 (source: American College of Obstetricians and Gynecologists reVITALize Initiative). The clinician, not the abstractor, should perform the calculation to determine gestational age.*

If the gestational age entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number or two different numbers are listed in the first document and the correct number can be supported with documentation in the other acceptable data sources in the medical record, the correct number may be entered.

Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).

It is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.

The EHR takes precedence over a hand written entry if different gestational ages are documented in equivalent data sources, e.g., delivery record and delivery summary.

Suggested Data Sources: ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE

- Delivery room record
- Operating room record
- History and physical
- Prenatal forms
- Admission clinician progress notes
- Discharge summary

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Key Impact: Labor
Rationale: Revise data element definition, collection question, allowable values, notes for abstraction and suggested data sources to conform with updated TJC measure specifications.

Description of Changes:

Data Element Name:	**Labor**
Collected For:	MAT-3
Definition:	Documentation by the clinician that the patient was in labor *prior to induction and/or cesarean birth.*
Suggested Data Collection Question:	Is there documentation that the patient was in labor *prior to induction and/or cesarean birth?*
Format:	Length: 1 Type: Alphanumeric Occurs**:** 1
Allowable Values:	Y (Yes) There is documentation that the patient was in labor *prior to induction and/or cesarean birth.* N (No) There is no documentation that the patient was in labor *prior to induction and/or cesarean birth* OR unable to determine from medical record documentation.
Notes for Abstraction:	A clinician is defined as a physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). Documentation of labor by the clinician should be abstracted at face value. There is no requirement for acceptable descriptors to be present in order to answer "yes" to labor. Documentation of regular contractions *with or without cervical change; i.e., dilation, effacement without mention of labor may be used to answer "yes" to labor.* *Induction of labor is defined as the use of medications or other methods to bring on (induce) labor. Methods of induction of labor include, but are not limited to:* o *Administration of Oxytocin (Pitocin)* o *Artificial rupture of membranes (AROM) or amniotomy* o *Insertion of a catheter with an inflatable balloon to dilate the cervix* o *Ripening of the cervix with prostaglandins, i.e. Cervidil, Prepidil, Cytotec, etc.* o *Stripping of the membranes when the clinician sweeps a gloved finger over the thin membranes that connect the amniotic sac to the wall of the uterus.*
Suggested Data Sources:	History and physical Nursing Notes *Medication administration record (MAR)* Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
The following are acceptable descriptors for labor: • Active • Early • Spontaneous	The following are not acceptable descriptors for labor: • Latent • Prodromal

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Key Impact: Parity
Rationale: Change data element name, revise definition, suggested data collection question, notes for abstraction and guidelines for exclusion/inclusions to conform to ACOG standardized description and updated TJC measure specifications.

Description of Changes:

Data Element Name: *Number of Previous Live Births*

Collected For: MAT-4

Definition: The number of deliveries *resulting in a live birth* the patient experienced prior to current hospitalization.

Suggested Data Collection Question: How many deliveries *resulting in a live birth* did the patient experience prior to current hospitalization?

Format:
Length: 2 or UTD
Type: Alphanumeric
Occurs**:** 1

Allowable Values:
0 – 50
UTD= Unable to Determine

Notes for Abstraction: *Parity may be used for the number of previous deliveries resulting in a live birth if zero is documented. For any number greater than zero, parity may ONLY be used provided there is additional documentation indicating the same number of live births experienced prior to this hospitalization*

The delivery or operating room record should be reviewed first for *the number of live births*. If *the number of previous live birth* is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for *the number of previous live births* is found. In cases where there is conflicting data, parity found in the first document according to the order listed *in the Only Acceptable Sources should be used.*

If gravidity is documented as one, the number of previous live births should be considered zero.
The previous delivery of twins or any multiple gestations is considered one *live birth* event.

Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).

It is acceptable to use data derived from vital records reports received from state or local departments of public health, *delivery logs or clinical information systems* if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the *Only* Acceptable Sources listed below.

If primagravida *or nulliparous* is documented select zero for *the number of previous live births.*

Suggested Data Sources: **ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE**

- Delivery room record
- Operating room record, *note or summary*
- History and physical
- Prenatal forms
- Admission clinician progress note
- Discharge summary

Guidelines for Abstraction:

Inclusion	Exclusion
• *None*	• *None*

Key Impact: Prior Uterine Surgery
Rationale: Revise guidelines for abstraction to conform to TJC measure specifications.

Description of Changes:

Data Element Name: Prior Uterine Surgery
Collected For: MAT-3
Definition: Documentation that the patient had undergone prior uterine surgery.
Suggested Data Collection Question: Is there documentation that the patient had undergone prior uterine surgery?
Format: Length: 1
Type: Alphanumeric
Occurs: 1
Allowable Values: Y(Yes) The medical record contains documentation that the patient had undergone prior uterine surgery.

N(No) The medical record does not contain documentation that the patient had undergone a prior uterine surgery OR unable to determine from medical record documentation.

Notes for Abstraction:
Suggested Data Sources: History and physical
Nursing admission assessment
Progress notes
Physician's notes
Prenatal forms

Guidelines for Abstraction:

Inclusion	Exclusion
The **only** prior uterine surgeries considered for the purposes of the measure are: • Prior classical Cesarean section which is defined as a vertical incision into the upper uterine segment • Prior myomectomy • Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury • History of a uterine window or thinning of the uterine wall noted during prior uterine surgery or during ultrasound • History of uterine rupture requiring surgical repair • History of a cornual ectopic pregnancy • *History of transabdominal cerclage*	• Prior low transverse cesarean section • Prior cesarean section without specifying prior classical cesarean section • *History of an ectopic pregnancy without specifying corneal ectopic pregnancy* • *History of a cerclage without specifying transabdominal cerclage*

Appendix A-10: MassHealth Specific Measure Calculation Rules

Key Impact: MAT-3 Measure Rule
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes, gestational age, labor and prior uterine surgery data element rules to conform to TJC specifications.

Description of Change:

- Row 21 change name to ICD-10-CM Principal or Other Diagnosis Code
- Row 23 change gestational age Rule statement
- Row 24 change name to ICD-10-CM Principal or Other Diagnosis Code
- Row 25 change name to ICD-10-PCS Principal or Other Procedure Code and update Rule statement
- Row 26 add entire Labor Rule statement
- Row 27 change name to Principal or Other Procedure Code and update Rule statement
- Row 28 minor change to Labor Rule statement

Key Impact: MAT-4 Measure Rule
Rationale: Update initial patient population ICD-9 references due to conversion of ICD-10 codes, gestational age, Number of previous live birth data element rules to conform to TJC specifications.

Description of Change:

- Row 21 change name to ICD-10-CM Principal or Other Diagnosis Code
- Row 22 change name to ICD-10-CM Principal or Other Diagnosis Code
- Row 24 Update gestational age Rule statement
- Row 25 change name to Number of Previous Live Births and update Rule statement
- Row 26 change name to ICD-10-PCS Principal or Other Procedure Code

Section IV. Updates to RY15 EOHHS Manual Versions Tracking

Table 1 - Summary of Changes in RY15 Release Notes (v8.1a) by Measures (Q4-2015)

Quality Measures	Measure Description (Section 3A to 3G)	Measure Flowchart	Data Dictionary	Abstraction Tool	XML Schema Data Fields	Measure Calc. Rules
All MassHealth Records	N/A	N/A	• ICD-10-CM Other Diagnosis Code • ICD-10-CM Principal Diagnosis Code • ICD-10-PCS Other Procedure Code • ICD-10-PCS Principal Procedure Code	N/A	N/A	N/A
MAT-1	Update IPP references for ICD-10	• ICD-10 references	• Gestational Age	None	• ICD-10 Coding • Gestational age	None
MAT-2a & 2b	Update IPP references for ICD-10	• ICD-10 references	• None	None	• ICD-10 coding	None
MAT-3	Update IPP references & ICD-10 code tables	• ICD-10 references • ICD-10 code Tables • Add evaluation of Labor	• Gestational age • Labor • Prior uterine surgery	Yes	• ICD-10 Coding • Gestational age • Labor • Prior uterine surgery	Yes
MAT-4	Update IPP references & ICD-10 code tables	• ICD-10 references • ICD-10 code Tables • Change 'Parity' data element name to 'number of live births'	• Gestational age • Number of previous live births (replaces Parity)	Yes	• ICD-10 Coding • Number of live births	Yes
CCM-1,2,3	None	None	• N/A	None	• ICD-10 Coding	None
ED-1,2	Update reference to NHQIM manual (v5.0a)	N/A	• N/A	N/A	• None (Crosswalk file)	N/A
TOB-1,2,3	Update reference to NHQIM manual (v5.0a)	N/A	• N/A	N/A	• None (Crosswalk file)	N/A

Table 1 Notes:

- IPP = initial patient population impacted by ICD-10 code conversion (this data element change applies across all MassHealth measures)
- Yes = change required;
- None = no change required;
- N/A = not applicable to reporting requirement
- ICD-10 coding = applicable to code data entry fields

Table 2 - Summary of RY15 EOHHS Manual Versions Tracker

RY2015 EOHHS Manual	V8.0	v8.1	EOHHS Release Notes (v 8.1a)
Section 1: Introduction	YES	YES	**YES**
Section 2: Data Collection Standards & Guidelines	YES	YES	**YES**
Section 3: MassHealth Quality Measures Specifications	YES	YES	**YES**
Section 4: Medicaid Sampling Specifications	YES	YES	**YES**
Section 5: Data Transmittal Guidelines	YES	YES	**YES**
Section 6: Data Validation Methods	YES	YES	**No**
Section 7: Health Disparities Measure Specifications	YES	YES	**No**
Section 8: Other Hospital P4P Program Information	YES	YES	**No**
RY2015 Appendix Tools	**V8.0**	**V8.1**	**New Version 8.1a**
A-1: Data Abstraction Tool: MAT-1	PDF*	---	***No (use v 8.0)****
A-2: Data Abstraction Tool: MAT-2a, 2b	PDF*	---	***No (use v 8.0)****
A-3: Data Abstraction Tool: (MAT-3)	PDF	---	**YES**
A-4: Data Abstraction Tool: Cesarean Section (MAT-4)	PDF	---	**YES**
A-5: Data Abstraction Tool: (CCM-1 CCM-2, CCM-3)	PDF*	---	***No (use v 8.0)****
A-6: XML Schema: MassHealth Specific Measures File (MAT, CCM)	PDF	---	**YES**
A-7: XML Schema: MassHealth Identifier Crosswalk File (ED, TOB)	PDF*	---	***No (use v 8.0)****
A-8: XML Schema: MassHealth Data Deletion Request File	PDF*	---	***No (use v 8.0)****
A-9: Data Dictionary: MassHealth Specific Measures (MAT, CCM)	PDF	---	**Updates in Release Notes 8.1a**
A-10: MassHealth Specific Measure Calculation Rules (MAT, CCM)	PDF	---	**YES**

Table 2 Notes:

- Version 8.0: YES = use for Q1-2015 to Q3-2015 data reporting. Full RY15 EOHHS Manual and Appendix version published.
- Version 8.1: YES = use for Q1-2015 to Q3-2015 data reporting. Updated EOHHS Manual but No change to Appendix tools.
- Version 8.1a: YES= use for Q4-2015 data reporting, except where otherwise noted (shown as *underline font with asterisk*).

Please contact the MassQEX Help Desk at 844-546-1343 or massqexhelp@telligen.com if you have any questions about information in this document or EOHHS Manual version instructions apply to reporting.